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MODERN TRENDS IN PSYCHIATRIC THERAPY*

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The pressing nature of the problem of mental and nervous disease is brought forcibly to our attention when we consider a few statistics. At the present rate of development of mental and nervous disease in the United States, one of every twenty-four people will at some time or other enter a mental hospital. On the basis of the average number in each family, this means that one in every seven families will be confronted with mental disease in one of its members. Of the more than seven hundred thousand hospital beds in the United States, more than four hundred twenty-five thousand are given over to the care of mental and nervous disease patients. At least a million children and young adults in school and college at the present time are going to a mental hospital, if not permanently, at least for study. These figures cannot but indicate the tremendous scope of the problem of mental disease. And the problem is not only a medical one; it has sociological and economic implications as well. For example, there are thirty or forty thousand yearly attempts at suicide, of which fifteen thousand are successful. A half million men, women and children go through the courts of the land and are sent to jails or to other penal or reformatory institutions. This is a definite challenge to psychiatry, and the ramifications of the challenge invade the sphere of general medicine, since it threatens the security of every citizen of our country.

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From the purely psychiatric viewpoint, there are five approaches to nervous and mental diseases, the classificatory, the genetic, the organic, the psychological, and the pharmacological or medical. The first, which was exhaustively developed by Kraeplin, may be called the classificatory or statistical approach. This consists in the grouping of similar symptom complexes, of fitting individual cases into definite nosological categories, and of hospitalization. This is essential in the care of psychotic patients, but is relatively unimportant. There is little need to pay an undue amount of attention to diagnosis. In many cases it is extremely difficult to determine whether or not one is dealing with a severe neurosis or a psychosis. There are a tremendous number of psychotic reactions in which intergrading is so prominent that it is impossible to classify them as dementia praecox or manic-depressive insanity. More important than the classification of the illness is the understanding of the individual in whom the illness occurs. *Why* has he or she become ill? What are the circumstances which conspire to produce the maladjustment, the result of which we observe? What can we do for the individual therapeutically? With such considerations of paramount importance, it is clear that the psychological and medical points of view overshadow that of classification, nosology and statistics.

Rudin, in Switzerland, has made searching investigations of the role of heredity in mental disease, especially dementia praecox. Slater has made valuable contributions to the understanding of the laws governing the inheritance of manic-depressive insanity. However, from the practical point of view so little is known and so much less can be applied that this phase of investigation is at present of little help to us in the care of the patient acutely ill. Again, if one considers the psy-

chotic tainting in the general population, one finds it not so very different from that of the families of a large group of psychotic patients. A point which must be considered in the collection of statistics upon which studies in heredity are based is the crass ignorance of informants, or their deliberate efforts to conceal mental disease in their families. Illustrative of this point is the rather unusual situation in a young couple just recently married. The wife is ignorant of the fact that her mother has had a psychotic breakdown. The husband does not know that his father died during an attack of insanity. The wife herself does not know that she has had a psychotic episode for which she was hospitalized. We can readily see, therefore, that were these people to give their family history to an examining physician, the hospital records would be negative from the standpoint of tainting, whereas, three members have had major mental illnesses. The enthusiastic investigation of the role of heredity is to be encouraged despite the many and transparent defects of methodology. With the more rigid standards, both genetic and anamnestic, studies of the future undoubtedly will be more applicable to clinical problems.

Neuropathological studies at the present time reveal little that is consistent or pathognomonic in the brains of patients with either dementia praecox or manic-depressive insanity. The work of Elvidge and Wilder Penfield, of Montreal, has shown variations in the oligodendroglial cells in psychotic states. Their work is recent and has not been confirmed. It does, however, present for our consideration a structural basis for aberrent mental states. The work of Lennox and Gibbs, and of Hoagland, Rubin and Cameron, has shown that in the field of electroencephalography there are objective alterations in the electrical rhythms of the brain. Lemere observed a consistent tendency toward a weak alpha rhythm in schizophrenics which persists even after a "successful" course of treatment with insulin. However, most constant and understandable to the neuro-physiologist are the electrical alterations characteristic of convulsive states.

In the early years of this century there was a tremendous emphasis on the psychological approach to mental disease. Under the aegis of Sigmund Freud, a great new field was described. Stimulating conceptions were presented to the profession, and an entirely different understanding of the mechanisms responsible for psychotic reactions was uncovered. The previously accepted belief that mental disease was static and fixed, and relatively hopeless, was replaced by an aggressive, dynamic and hopeful therapeutic attitude. The sense of therapeutic impotence, and the narrow, custodial avenues of management were altered by the invigorating ideology made available by Freud and his psychoanalytic school. Psychoanalysis drew psychology away from that sterility which only those who have been exposed to academic psychology can appreciate.

In the early days of its existence, psychoanalysis was bitterly condemned by the medical profession. It was considered a pseudoscientific hypothesis, the tenets of which were obscured by esoteric jargon. The emphasis placed upon sexual motivations was decried and zealously assailed. Nonetheless, one cannot properly appreciate the advances made by psychiatry without giving to Freud and his coworkers generous recognition for their significant contributions.

Our comments upon the Kraepelinian, the genetic, the neuropathological and the psychological approaches have been unduly but necessarily brief for the reason that we are most anxious to discuss the medical approach to mental and nervous disease. We wish to report to you the experience which we have had in the Pennsylvania Hospital with three of the newer methods of treating the psychoses, i. e.: narcosis therapy, insulin therapy and metrazol or convulsive therapy. These comprise three important treatments in the medical approach to functional mental disease. We might digress here to state that if we follow any single approach exclusively we are seeing neither the psychosis nor the individual as a whole, and treatment is bound to be partial and ineffectual. The psycho-biological conception of Adolph Meyer stresses the importance of con-

sidering the total individual and the totality of his experiences in attempting to treat him.

In 1928, Manfred Sakel, a young Viennese psychiatrist, while working with morphine addicts, attempted to devise a method of controlling the restlessness, irritability and uncooperative attitude of these patients during withdrawal. He noted a similarity between abstinence symptoms and the restlessness of Grave's disease. Empirically, he resorted to the use of moderate doses of insulin to quiet his patients. He observed that insulin enabled them to tolerate the period of morphine withdrawal with a greater degree of subjective comfort. Accidentally, some of his patients developed hypoglycemia, following which they were improved both psychologically and physiologically. Irritability was replaced by a more agreeable attitude, and depression and confusion were replaced by cheerfulness and lucidity. He was much impressed with the physical and psychological shift which resulted from hypoglycemia. He developed the hypothesis that perhaps insulin, with its hypoglycemic effects on the organism, would be of use in treating the psychoses. Following its careful use, he noted that the shy, autistic individual became more sociable and accessible. With this objective confirmation of his happy thought, he developed a method with many safeguarding precautions and applied it to dementia praecox. He gave ascending doses of insulin to fasting patients, deliberately attempting to produce deep hypoglycemic coma. The doses employed were such that we would have viewed them with grave alarm. As a matter of fact, in the Pennsylvania Hospital years ago, we used insulin in malnutrition and, in the published report, incorporated a warning concerning dosage lest insulin shock develop. Strange to say, on looking back on some of our cases, we found that those responded most favorably who had mild degrees of insulin shock.

According to Sakel's technique, when coma was produced by daily increasing doses of insulin, patients were permitted to remain in this state for two or three hours. The coma was then relieved with glucose by nasal tube or by intravenous glucose.

We would like to show several slides in which are incorporated the results of special therapies in the Pennsylvania Hospital.

In Slide 1 (Table 1) are included the results obtained in twenty-two clinics throughout Switzerland, Germany, Austria and France. From the percentage of recoveries which include full recoveries and social remissions, it is evident that it is extremely important that patients be treated early. In those ill less than six months, sixty-five per cent show partial or full remissions. Recovery drops off in a sharp gradient, so that those who are ill more than a year and less than two years show only a thirty-one per cent recovery rate, while in the group whose illness has been in excess of two years, only fourteen per cent recover.

TABLE I

INSULIN THERAPY
(M. Muller)
(Berne)

Duration of Illness	Total No.	S.R. & F.R.	Per Cent.
6 mos.	190	124	65.3
½-1 yr.	62	38	61.3
1 yr.	252	162	64.3
1-2 yrs.	76	24	31.6
More than 2 yrs.	99	14	14.1

In Slide 2 (Table 2) is reported seventy-nine cases treated in the Pennsylvania Hospital. Our percentage of full recoveries is 30.2%. Those that are doubtful comprise 16.3%. These patients are at home but are not sufficiently free of symptoms to be called remissions. 52% showed lack of any favorable response.

TABLE 2

Pennsylvania Hospital—Insulin Therapy

Dementia Praecox	Rec.	Unrec.	Doubt
79 Cases	24	42	13
	or	or	or
	30.2%	52.9%	16.3%

The disparity of our statistics and those reported from Europe is explicable on several bases. The first of these, and perhaps the most important, has to do with the difference in diagnostic criteria. Many patients who show schizopherniform behavior or delusion formation as partial factors in a picture predominantly affective are excluded from the category of dementia praecox in the Pennsylvania Hospital. Such patients would undoubtedly be grouped as schizophrenics in

European clinics, where evidence of dissociation is the most important element in the diagnosis of dementia praecox. In addition, we have applied a very stringent critique in judging the quality of our recoveries.

There are many interesting elements in the actual application of the treatment entirely aside from the statistical results. The insulin method of treating dementia praecox has infused into psychiatry a new spirit of investigation. The chemo-physiological aspects of mental disease are being enthusiastically examined. The relationship between the depth of coma and blood sugar has been found to vary widely. In fact, there is no constant relationship between these two phenomena. Wide variations in the degree of sensitivity to insulin have also been observed; and whereas one patient may go into profound shock with five units, another will be resistant to doses as high as seven hundred units. The average coma-producing dose of insulin given on a fasting stomach varies between ninety and one hundred units.

Another interesting physiological observation is that shock or coma does not necessarily appear when blood sugar is at its lowest level. The blood sugar may actually be increasing when coma develops. Georgi assumes that the cause of hypoglycemic convulsions is a difference in sugar potential between the brain cells and their milieu. A great body of careful work points to the role of anoxemia in the production of coma. Insulin shock interferes with the utilization of oxygen by the brain by burning the substrate; and Gerard has stated that neurological signs incident to hypoglycemia parallel the glycogen content of the brain far more closely than they do the sugar content of the blood.

Sakel has advanced a theoretic interpretation of the part which insulin coma plays in the psychological reformulations of the individual. He believes that there is an obliteration of the most recently acquired patterns of thinking, which enables the individual to fall back on earlier and more normal pathways. (Stanley Cobb has severely criticized the hypothesis advocated by Sakel.)

From a standpoint of scientific objectivity and conservatism, we will not be able to evaluate properly the permanent efficacy of insulin therapy for many years. It may be soon replaced by a more direct and simpler approach to the problem. However, we are unable to say other than that positive therapeutic successes have been observed from its use, and that it has been the spearhead in an era of active and productive research.

Metrazol therapy makes use of a cardio-respiratory stimulant which is known by a host of proprietary names, such as Corvis, Cardiazol, etc. Its use in psychiatry was recommended originally by Ladislaus von Meduna, a psychiatrist in Budapest. Meduna was aware of a report by Nyiro and Jablonsky who reported that sixteen per cent of their epilepties ceased to have convulsive attacks when they developed dementia praecox. He was impressed also by a report of Steiner and Strauss, who discovered but twenty convulsions among six thousand cases of schizophrenia reviewed. Feeling that there was a mutual antagonism between the convulsive state and the schizophrenic process, he extended his work from experimental epilepsy to the clinical application of convulsive therapy in mental patients. He had worked with a host of analeptic agents, finally denominating metrazol as the safest and most consistent in its effect.

The following table comprises the statistics collected by Emerick Friedman of all the cases treated in Europe and America up to May of 1937:

EMERICK FRIEDMAN—COLLECTED STATISTICS

Total Cases	2,937
Early Cases Recovered	60%
Chronic Cases Recovered	8.36%
Chronic Cases Benefitted	37.76%

Friedman's statistics again point out the necessity of early diagnosis and treatment. Of the early cases treated of a group of 2,937, sixty per cent recovered. Of the chronic group treated, only eight per cent recovered.

At the Pennsylvania Hospital we have used metrazol therapy in manic-depressive psychosis and in involutional cases as well as in dementia praecox.

PENNSYLVANIA HOSPITAL METRAZOL THERAPY

Results	D. P. 25	M. D. 11	In. M. 2	P. N. 1
Recov.	5	6	1	0
Much Imp.	2	3	0	0
Imp.	12	2	0	1
Unimp.	6	0	1	0

This series was reported to the American Neurological Society in May of 1938, by Strecker, Alpers, Flaherty and Hughes. In the schizophrenic group, twenty-five patients were treated who had previously proven refractory to insulin therapy, and numbered among this group were ten patients who were ill for periods in excess of five years. Five, or twenty per cent gained a full remission.

Prior to the use of either insulin or metrazol therapy, the so-called narcosis treatment, or prolonged sleep, was widely employed in psychiatry. Klaesi, a Swiss physician, perhaps contributed most generously in the formulation of method and the popularization of the treatment. According to his technique, patients were kept in deep sleep for periods varying from a week to ten days. The sedative which he used was Somnifen, a drug which is rarely employed in this country. He maintained nutrition in his patients with rectal feedings and allowed them to be aroused only for short periods each day. It was his belief that the profound rest had a beneficial effect upon the hyperexcitability of the brain and nervous system. It was believed that this method increased the recovery rate in clinics throughout the world by about ten per cent.

The following statistics which we show through the courtesy of Drs. Palmer and Braceland, of the Pennsylvania Hospital, give the recovery rate in one hundred cases which were treated by sodium amytal narcosis. The method which we employ at the Pennsylvania Hospital consists of the administration of gradually increasing doses of sodium amytal until deep and continuous sleep is obtained for 18 to 22 hours of each day. During the first day of narcosis the required number of hours of sleep is obtained with a dosage varying between 9 to 15 grains. Thereafter the sedative requirement rises very rapidly until the sixth or seventh day, when a maintenance dose varying between 30 to 60 grains a day, obtains the desired effect. In some cases an amazing tolerance can be observed, as in one of our cases in which 340 grains were administered in one day to obtain 17 hours of sleep. We allow our patients to awaken twice daily for feeding and nursing care.

Narcosis Therapy	Recov.	Perm. Imp.	Temp. Imp.	Unch.	Total
Manic-Depressive	23	5	8	10	46
Dementia Praecox	10	5	10	21	46
Involutional Melancholia	....	1	1	1	3
Psychoneurosis	1	3	1	0	5
Total	31	14	20	32	100

Of this group of one hundred, 46 were cases of dementia praecox, of which number, ten, or 21.7%, recovered.

Although each of these methods have their enthusiastic exponents, it is probably correct to say that the consensus of opinion regards insulin as the most favorable method to employ in dementia praecox. Metrazol, with a wide extra-schizophrenic application, is less valuable than insulin; the narcosis therapy the least valuable of the three methods in the treatment of schizophrenia.

All of these three methods are heroic measures and inherent in each are dangerous complications. It is only by the exercise of constant vigilance and the maintenance of a skilled personnel, that the treatments can be employed without grave sequelae. There is a definite threat to life in each treatment and unavoidable deaths are somtimes encountered. In insulin therapy the danger of prolonged coma and status epilepticus should be stressed, as well as the occurrence of hemiplegia and subarachnoid hemorrhage. In metrazol therapy, cardiac complications as well as fractures and dislocations of the extremities, and what is perhaps most ominous, fractures of the vertebral bodies, especially in the thoracic region, are encountered. In narcosis therapy the danger of cardio-vascular collapse, pulmonary complications and cerebral thrombosis in the older age group, are potential threats to the safe conduct of treatment.

Numerous physiological studies have been made since the introduction of these three

methods of treatment in an attempt to determine the factors which influence the remissions observed. These observations have given us a more complete understanding of dementia praecox. Although in ordinary hospital records the physical examination and the neurological study of schizophrenics are for the most part said to be normal, our biochemical and neurophysiological studies have revealed numerous subtle differences which elude clinical examination. For example, it is significant that in the majority of cases of dementia praecox heat production is lower than normal, general nutrition is not as well maintained and the basal metabolic rate is lower than normal in the majority of cases. Nolan Lewis long ago pointed out the tendency of schizophrenics toward a hypoplastic cardiovascular system. The theory that there is a sluggishness or hypo-reactivity of the sympathetico-adrenal system in schizophrenia, is widely believed. Gellhorn suggests that there is an abnormality of the entire autonomic system in dementia praecox. Pfister reports that in dementia praecox the blood sugar following insulin returns to normal less rapidly than in normal people, indicating, perhaps, a hypoadrenia. We find, therefore, that insulin therapy, by the induction of hypoglycemia, anhydremia, anoxemia and a difference of sugar potential between the cell and extra-cellular spaces, produces a violent shock which is stimulating to the total organism, especially the sympathetic nervous system.

Despite the dramatic changes induced in the physiology of the organism, there are unquestionably profound psychological factors involved which cannot be ignored. The leading protagonists of the treatments described, including Klaesi, Sakel and Meduna, stress the psychic elements involved and the necessity of parallelling the treatments with psychotherapeutic interviews. Among the psychological factors of greatest import are the extremely serious character of the therapy and the consequent necessity of treating patients with all the care and attention involved in a surgical or grave medical situation. Contained in the drastic therapies are elements which impress on the mind of the patient the menace of a death threat. It is possible that through this appreciation is stimulated the biological urge of self-preservation. The importance of this factor psychologically is emphasized by numerous investigators. As you know, in dementia praecox we find the active schizophrenic who is antagonistic, paranoid and aggressive, and the passive schizophrenic who is autistic, seclusive and withdrawing. The one actively rejects human relationships, the other withdraws from them. The end result in either case is the denial of a personal relationship to reality. During the drastic therapies these patients are thrown into a state of enforced dependence on individuals about them. They must accept the ministrations of nurses and doctors. Impelled by the menace to life, which probably has no conscious formulation, they reach for and accept the help which is extended to them. Contained in this situation, namely, that of reaching out for help and security from those about them, are the seeds of an improved rapport with the environment and the genesis of a more normal mental and emotional orientation.

In all of the newer treatments it is vital that the individual physician be absorbed in communicating to the patient healthier attitudes and a better pattern of adjustment. Undoubtedly from the amount of attention alone, a great psychological dividend is derived, but most important is the inculcation of a normal standard of values and a dynamic insight into the illness. The new therapies are more effectual as they are more closely associated with enthusiastic and competent psychotherapy.

In conclusion we shoud like to mention the work of Egas Moniz, a Portugese surgeon who introduced lobotomy or frontal leukotomy. There are very few institutions in America in which this operation has been performed. We do not employ it at the Pennsylvania Hospital. It is, however, being done in a hospital which is very progressive and we are very proud to feel, as it were, that we are in the same community with that progressive hospital. It has taken the lead among state hospitals in doing this work. That hospital is your own, under the leadership of Dr.

Tarumianz. Any remarks on the newer methods of treatment in psychiatry should not only include the chemical methods which we have described, but also the surgical approach about which Dr. Tarumianz can speak from a position of very ample experience. We thank you.

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PSYCHONEUROSES IN RELATION TO GENERAL MEDICINE

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In order to understand the relation of psychoneurotic manifestations to clinical medicine in all its ramifications, one must endeavor first of all to form a clear conception of the underlying factors capable of producing functional disturbances in the domain of the nervous system. Not infrequently it happens, as we all know, that when an individual develops, for any reason at all, subjective disturbances referable to the ear, nasopharynx, or larynx, the oto-laryngologist is consulted first. Should the subjective disturbances have an apparent relationship to the function of the ovaries, or to that of the vesical and biliary organs or of other abdominal viscera, to the function of respiratory and cardiac organs, to the function of the eyes, in all such cases the respective medical or surgical worker will be consulted first. Such an attitude on the part of the lay-patient is psychologically logical and correct. But from a medical standpoint, as we know, the above attitude not infrequently leads to serious errors. That is to say, there are disturbances which have no fundamentally serious relationship to any given abdominal or thoracic viscera, but belong to purely mental functions which, for reasons of a psychic character dissociated the work of the various elements which enter in formation of harmonious display of organs and tissues. What precisely characterizes the individual in all such cases is not the multiplicity of symptoms, not tne innumerable functional disorders which may simulate organic diseases, not the painful sensations which he or she experiences, but only a special state of mind, a special mentality.

Human machinery is so complex in its various operations that every one of us, otherwise sound, experiences now and then some indication of a functional disorder; either there is a gastric manifestation, or a vague pain, or a cardiac palpitation or a fugacious neuralgic discomfort. But being normally constituted, we give all such symptoms their proper interpretation, our attention is not firmly arrested on them, we continue our ac-

tivities in spite of them. Furthermore, we are able to overcome unpleasant circumstances which may arise at any time, we may even surmount obstacles of a most serious nature. Our relative indifference to all such conditions constitutes a normal state of mental health.

On the other hand, the individuals whose attention is held firmly and for a prolonged period of time by those subjective disturbances enumerated above, who view the least unpleasant event as a catastrophe, who develop obsessive ideas and hold on to them for months and years, whose association of ideas is such that fears, anxiety and abnormal inhibitive or abulic phenomena make their appearance with the greatest facility and apropos of insignificant occurrences, whose suggestibility and auto-suggestibility are exaggerated, whose reactions to external or internal stimuli are intense—all such personalities present a type apart, an abnormal type of humanity and therefore require special consideration.

Some fuller elaboration of this category of individuals is now indicated for a clearer understanding of the subject under discussion. First of all, psychoneuroses should be firmly distinguished from mental deficiency. The latter is usually congenital and inherent and is the direct result of a morphological or physiological abnormality of the nervous structure. Of course psychoneurotic manifestations may appear in mentally defective individuals, but there is no unusual relationship between the two and we are considering here only intellectually normal cases. Psychoneuroses are fundamentally psychogenic and develop in the midst and because of abnormal psychological experiences. Before discussing these experiences, let us present a few examples of psychoneurotic manifestations.

One female patient, aged twenty-eight, following a normal confinement with no undue loss of blood and with a prompt recovery, misinterpreted her very slight serous vaginal discharges, which she explained to herself as due to a serious affection of her genitalia. Otherwise perfectly sound, she consulted a number of gynaecologists who treated her by various methods, and two of whom performed curetting. The woman became very much depressed, she felt very unhappy and was in constant fear of malignancy, physical or constitutional, without an actual basis of it. Subsequent events proved that her belief was only psychogenic, as she made a complete recovery under a psychotherapeutic management.

A young married woman, twenty-five, was suffering with chronic constipation. She would occasionally have headache. Coming frequently in contact with a female friend who also had headache and who attempted to commit suicide in a fit of jealousy of her husband, my patient developed an idea that her friend became insane because of the pain in the head, and therefore her own headache might in the future lead to the same consequence. She was in constant fear of such termination. She was advised to consult an oculist, who promptly refracted her eyes and told her that the proper glasses would cure the condition. For two years she was in a state of fear and anxiety without any relief. She consulted a gynaecologist and also a general surgeon at different periods. The former curetted the uterus; the second operated for suspected adhesions of transverse colon. Neither the glasses, nor the curettment, nor the operation on the colon removed the original mental condition although every one of the three men assured her that the removal of the condition which they considered respectively as the sole morbid cause would undoubtedly bring about a complete cure. Under psychotherapeutic measures during a short period of time the fear and anxiety as well as the slight headache have all disappeared.

A young man of twenty-five, during a period of three years complained of disturbances referable to almost every organ in his body. At first it was the heart, then the gallbladder, then the nasal cavities, the ears, the eyes, the genitalia, rectum and finally the right hypochondrium. Numerous physicians in and outside of hospitals were consulted and everyone advised and actually performed some manipulations or small operations. Some of them advised dross abdominal operations. For the latter of his multiple com-

plaints a surgeon advised an appendectomy. Accordingly the patient was placed on the operating table. While the preliminary preparations were being made, namely, the assortment of the instruments, washing the hands of those who were to participate in the operation, etc., the patient was suddenly seized with a fright, refused to be operated on and at once left the hospital. Since then there has been no return of pain in the right hypochondrium. Towards the end of his peregrinations, he observed a slight cloudiness of his urine. At once he conceived the idea of a kidney affection. Again he consulted several internists, each of whom made a different diagnosis. It was at that time that the writer had a good opportunity to see and keep him under observation. It must be mentioned at this juncture that during the entire illness of several years' duration the patient continued uninterruptedly his usual occupation, namely, that of a railroad conductor. He always slept well and had a voracious appetite.

At the time of the examination there was no doubt in my mind as to the psychogenic origin of all the complaints of the patient. Psychotherapeutic management alone succeeded in removing the last obsessive ideas. He is well at present, but since such disorders are episodic in character, the probabilities are that new hypochondriacal manifestations will eventually make their appearance when confronted with new emotional factors, the nature of which will be discussed later.

A girl of seventeen developed abulic phenomena. If, while crossing a street she would notice a loose brick on the ground, she would be seized with fear and a state of extreme anxiety; she could not and would not step over the object, but would go around it and continue her gait. When, however, she would make an effort to overcome her deficient will power, she would tremble, cry and stop. Being slender and pale, and having irregular and scanty menstruation, she was taken first of all to a gynaecologist, whose diagnosis was anteversion of the uterus and that the latter was the direct cause of her psychoneurosis. He urged an operation. A general surgeon consulted subsequently spoke of uterine adhesions and advised some surgical procedures, the nature of which I could not determine. A laparotomy was performed with the result of a decided intensification of her psychic condition, as well as of her menstrual difficulties.

Examples, such as the few related, could be multiplied, but they are sufficient to demonstrate that besides a physical there is also a psychological approach which, after all, may be the most important, if not the only method in managing psychoneuroses. An organic or structural lesion can no more be viewed as the sole basis of functional psychic disorders.

In order to know how to manage these peculiar phenomena, let us briefly consider their nature and their meaning.

The behavior of every individual is the result of an interrelation of several elements, namely, emotional instinctive tendencies, such as fear, anger, self-assertion, attachment, etc., also the environmental conditions. The instinctive tendencies will have a different coloring in different individuals according to inherited qualifications, that is to say, a highly or less sensitive person will manifest his or her emotional elements in different ways. The constant interaction between these instinctive emotions and environmental objects or occurrences produces complex psychological states or complexes. We live, therefore, in the midst of daily or hourly conflicts between the inherent and exterior elements. Complexes are being created continually. When they are recognized by the individual self, the conscious ego is able to overcome them and the normal state is maintained and not disturbed. Many complexes, however, are not recognized, and since all complexes are different from each other and have a different aim and purpose, antagonism of one to another is constantly being created. As they are not recognized, the conscious ego has no control over them, and they may remain with us an indefinite time and are apt to create functional nervous disorders or psychoneuroses. In fixed ideas, obsessions, fears, states of anxiety, abulias, etc., in all such cases, as we have seen from the histories of the few patients cited above, the physical symptoms

alone emerge, such as pain in the hypochondrium simulating appendicitis, pain in the cardiac or pulmonary region simulating a disease of the heart, of lung, etc., but the emotion associated with the fixed ideas remains, and as long as the latter is unaltered or not removed, the physical manifestation remains and the patient will continue being unhappy and a sufferer.

The various physical manifestations of psychoneuroses may be relieved, and the individual may find with an effort on his part a certain skill in adapting himself to his environment and become more or less contented for the time being. But such a situation is not a cure, because the essential element in the conflict of various complexes has not been attacked, namely, the emotional instinctive factor, which plays the most important role in the psychoneuroses. It is not only the adaptation to the environment, but also and more emphatically the adaptation to oneself that is important. Otherwise speaking, a psychoneurosis can be removed only when the sufferer is shown how to unravel and lay bare the elements of the complexes which are in constant conflict so that to fit him to face himself. Attempts to remove physical discomfort will not remove the emotional elements which have created the psychic discomfort and which the patient will continue carrying with him indefinitely.

The inability to understand this essential principle, and the want of desire of considering a psychological end in human suffering besides a purely biological end, are the cause of failure of treatment. Therein lies the reason for the fact that very frequently the cause of psychoneurotic disorders is sought elsewhere, in the uterus, ovaries, in the genitalia in general. Next in order is the digestive apparatus that is not infrequently incriminated. Dilation of the stomach, gastroptosis, enteroptosis, nephroptosis, and cholecystitis are all conditions that are thought of and major operations are being performed. Not only is there total therapeutic failure as far as the patient's complaints are concerned, but undesirable local and general consequences may arise which will render the operated individual organically unfit in addition to his psychic unhappiness. As one of many examples of this particular contention I may call attention to the damage produced by castration in women.

In 1914 in a paper read before the American Medical Association (Vol. LXIII, p. 1345) the medical histories of 113 women who underwent complete or partial removal of the uterus or ovaries or of both, were presented and very extensively discussed from the broadest standpoint by internists, general surgeons, gynaecologists and neurologists. It was shown that the preexisting nervous and psychic phenomena for which the operations were undertaken became aggravated in the weeks and the months following the operations. The obsessions and other psychoneuroses with which several women suffered prior to the oophorectomies became, since then, more persistent and covered a larger field of morbid ideas than heretofore. These who suffered with hysterical paroxysms began to have them in a more accentuated form and more frequently. Former hypochondriacal and anxiety states became deeper. All such cases were referred to the gynaecologists with indiscriminate assurances that their vague nervous manifestations were exclusively due to indefinite gynaecological conditions. Of course the operations were uniformly successful, but the victim's existence was rendered most unfortunate and distressing. It was evident that partial or complete hystero-oophorectomies disturbed the well-established physiologic effect of ovarian tissue on the economy or perhaps disturbed the intimate relationship between various ductless glands which, as we have some reasons to believe, exist. At all events, in addition to the preexisting psychic phenomena additional disturbances were thus created.

The foregoing observations are sufficiently illustrative to contend that the real cause of psychoneurotic phenomena does not lie in accidental occurrences, such as traumatism, fatigue or local diseases, etc. These factors react on us all daily, hourly, and do not produce disorders of a permanent nature. A psychoneurotic individual on the contrary reacts differently because of the special make-

(*Concluded on page 207*)

EDITORIAL

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VOL. XI SEPTEMBER, 1939 No. 9

THE BATTLE OF 1940

Democratic Senator Wagner's (N. Y.) National Health Bill (S. 1620) was still in committee when Congress adjourned. Increased funds for national and child welfare were tacked on to amendments to the Social Security Act (H. R. 6635) as Congress was closing. Republican Senator Lodge (Mass.) introduced a bill (S. 2963), to provide certain medical benefits for a special class of unemployed, which likewise was in committee at the time of adjournment. The issue, temporarily disposed of, is not dead by any means; it will *certainly* be resurrected when Congress convenes again in January. The Democrats will contend for the Wagner Bill: the Republicans, as a counter lure for November Presidential votes, will have a health program of their own. In this connection the following report, from the *Ohio State Medical Journal* for September, 1939, is of unusual interest:

A prediction that "in 1940 a Federal medical program of some kind will be adopted" and a warning that "what form it takes depends largely on the medical profession" were voiced at the recent cornerstone laying ceremonies for the new Doctors' Hospital, Washington, D. C., by the Hon. Robert A. Taft, junior United States Senator from Ohio.

Inasmuch as Senator Taft is one of the leading contenders for the Republican nomination for President of the United States, his statements and observations pertaining to the medical and health activities of the Federal government and to proposed health legislation are of peculiar interest and importance.

TEXT OF ADDRESS

The complete text of Senator Taft's address follows. It should be read carefully by Ohio physicians. Those of his physician-constituents who may have the urge to express to Mr. Taft their views on the subject he discussed, should feel free to do so:

* * *

"It gives me the greatest pleasure to say a few words at the laying of the cornerstone of the Doctors' Hospital here in Washington. Almost unique among similar enterprises of the present day, this building is being constructed entirely from private resources, without government assistance of any kind whatsoever.

"It is designed to provide two hundred and fifty additional hospital beds for the District of Columbia, of a simple but efficient character, designed to reach patients who can pay approximately six dollars a day either from their own resources or as members of the hospital associations, which have been extended so widely in the District of Columbia.

LAUDS MEDICAL PROFESSION

"It has been organized, and the money raised by doctors, to meet the local need for hospitals, in a city which is perhaps growing faster than any other city in the United States because of the increased activities of the government departments. I enjoy the opportunity of praising the initiative of the medical profession of the District of Columbia in working out its own problems without lying down on the government.

"To some extent the medical profession is subject to the same criticism which is often directed at members of the legal profession. The abler members of the profession are likely to become so busy in their own practice that they pav too little attention to the question whether the profession as a whole is covering adequately its whole broad field of public service. Because their own task is well done, they are likely to feel no great concern about the question whether the administration of law or the administration of medicine is serving the public and the country as it should.

"Of course this is only a generalization, for countless reforms in the field of law have been initiated by lawyers, and countless reforms in the field of medicine by doctors. Here today we see how constructive enterprises are carried through to success if a few men are willing to devote their time and energy to the task.

DISCUSSES WAGNER BILL

"We have before us in Congress today the National Health Bill introduced by Senator Wagner, proposing to extend vast Federal assistance throughout the field of public health and medical care. It appropriates, out of our growing deficit, approximately $100,000,000 of Federal money the first year, and gradually increasing sums thereafter, until in ten years it will cost the Federal government more than $400,000,000, and require the states to supply approximately the same amount. This money is to be distributed to those states which have adopted state plans in various fields of medical work.

"In general the character of the plan is left to the state, but the appropriation of money collected from all the states to those states which go along with the program forces all the states as a practical matter to adopt some plan in each one of the fields covered by the bill. Six categories of state activity are provided for, namely: maternal and child welfare, handicapped children, public health work, hospitals, general medical care and sickness insurance. The bill has been strenuously attacked by many witnesses from the medical profession, and is not likely to be pressed at this session, but I believe that in 1940 a Federal medical program of some kind will be adopted. What form it takes depends largely on the medical profession. I am most hopeful that the doctors determine what comprehensive program can be adopted to improve the health of the American people, and that they propose a practical measure to assist that program.

BACKS DOCTORS' VIEWS

"The present bill seems to me needlesslv complicated. Its administration will take place under three different Federal departments. Every state must adopt at least six separate plans, and for each plan there is an Advisory Committee, so that the bill will create approximately three hundred different boards, largely composed of laymen. Surely the Federal health program ought to be consolidated under one head, and each state program ought to be worked out as far as possible under a single state department.

"The doctors feel very strongly, and I think justifiably, that while the Wagner bill does not itself contain specifically a program of socialized medicine, it is proposed by those who favor socialized medicine, and is open to the suspicion that it will afford a vehicle through which they may put their state-controlled medical care into effect. I feel confident that proper amendment of the bill can prevent such a result. We should be, above all, concerned that every patient retain the right to select his own physician, so that the personal relationship may not be disturbed, and the success of the individual physician may depend on his real ability instead of his political connections. We should be concerned that no great proportion of the doctors become employees of government. I see no reason why the present condition of individual service should not be preserved, even though we adopt the principle of Federal financial assistance.

SAYS CLAIMS EXAGGERATED

"Undoubtedly the deficiency in medical service in many parts of the United States has been exaggerated in the report of the sponsors of the bill, but nevertheless there is a lack of such service, resulting principally from the poverty of millions of American citizens. Unable to pay for medical service, they find no service at all in some rural sections: or they find the free service supplied by their cities or states inadequate or ineffective; and they may not be fortunate enough to receive any of the tremendous amount of charitable service provided by physicians themselves. Of course nothing is more important than health in meeting the problems of the average family, and, if possible, it is even more important to those unable to pay for assistance than it is for those who are better off financially.

"There are those who question the wisdom of any Federal assistance in the health field, but as in the case of relief and old age pensions, we have found that the states and localities have practically exhausted their financial resources in dealing with the established activities of government, like schools, roads and city services. They were unable to push into the new field of assisting those classes who receive inadequate income, through relief and old age pensions. Most localities and states have undertaken health work, but do not have the funds to make it universally effective. Some localities have never been able to undertake it at all. Assistance from the Federal government in some fields is essential, and such assistance seems to me justified in the field of public health, providing it is in a reasonable amount to meet real needs in a sensible and economic manner.

"The sponsors of the present bill seem to grossly exaggerate the lack of hospital service in the United States. Disregarding all private hospital service, they apparently plan a vast system of public hospitals to take care of everybody who would like to go to a free hospital. Any hospital plan should certainly encourage the construction of private hospitals and their use by public and private patients to their full capacity. It should encourage private plans of hospital insurance, which will assist the success of private hospitals, and reduce the expense of operating public hospitals.

FAVORS PRIVATE ENTERPRISE

"The construction of this Doctors' Hospital here in Washington shows that a large part of our problem may be met without the pouring out of more millions from the Federal Treasury, and without turning over to some state or Federal official the entire determination of who shall receive hospitalization and when he shall receive it; and the hospital plan ought to be worked out deliberately to encourage philanthropic persons to invest their own money in the extension of private hospital service, as they have so liberally invested it during the past fifty years.

"There is hardly a field in which there has been more sensational and continuous improvement than that of medicine in the United States. That improvement has been due to the brilliant, unselfish and industrious work of thousands of physicians. It is not their fault that incomes are unequally distributed, and that efforts by local government to cover the entire field of health have been restricted by lack of resources. But now I hope they will take an active interest in seeing that the unequalled medical service received by most Americans is extended to the entire population. Their own interest and participation in the program will make it certain that it is not dominated by half-baked theorists, or by those who believe in a totalitarian state, direct-

ing the lives and caring for the health of all its citizens through the mechanical and usually careless action of government bureaus. I believe a Federal aid program can be worked out. I believe it can be much simpler and more more economical, and much more likely to preserve the essential independence of the doctors than the present Wagner bill. I believe it can be worked out with the assistance and cooperation of the doctors themselves."

Continuing the subject with candor and perspicacity the *Ohio Journal* says editorially:

Let's take a look at the political and legislative horizon . . . . there lies the destiny of medical practice . . . . . there poise the challenges which will confront the medical profession as the crucial year 1940 approaches.

FEDERALIZED MEDICINE TO BE HEATED ISSUE IN 1940 CAMPAIGNS

Significant, or not, the following developments and observations are compiled for analysis by the alert physician who has his ear to the ground and his eye on the immediate future. . . .

Starting at the top, we find the pledge given the Young Democrats' Convention by the President of the United States to fight control of the nation by conservatives and his appeal that the voters be given "an opportunity to maintain the practice and the policy of moving forward with a liberal and humanitarian program" . . . . nothing specific mentioned but in the light of what has been tried at Washington and what is left in the way of proposed experiments, much may be inferred.

What of McNutt . . . Paul V. . . . former liberal governor of Indiana . . . new Federal Security Administrator . . . Presidential candidate? Was the address which Mr. McNutt made to the assembled Young Democrats, referred to above, his sounding board . . . his platform? Be that as it may, the following excerpt from his address carries a prophecy of significance to physicians who are wondering about the 1940 developments. . . . "The Social Security system is, of course, incomplete. It will be strengthened and enlarged often in the years to come. As it stands today it contains obvious gaps which undoubtedly will be filled in the near future. I refer, for example, to provisions for economic loss due to disability and for public health and medical care. In addition, there is still work to do on the great problem of old-age security". . . .

Thus spoke Administrator McNutt . . . but that's only half of it if the dope of the twin dopesters, Pearson and Allen, of Washington Merry-Go-Round fame, is authentic . . . they're pretty close to the throne on most occasions. . . . Let's examine what Pearson and Allen said in their "merry-go-round" column on July 19 . . . quoting in part:

"There was a reason why Paul McNutt took his oath in the office of Dr. Thomas Parran, head of the Public Health Service, and also will have his headquarters there. . . . That is the tip-off to his real job as chief of the new Federal Security Agency. . . . His interest will be centered on the New Deal's social medicine program. . . . He will drive to prepare the ground for the enactment of legislation next year. . . . What form this legislation will take is something McNutt will work out with medical leaders and experts. The Wagner Bill will be the starting point."

What medical leaders . . . what experts? Is there any significance in the appointment by Administrator McNutt of Mary Switzer as his executive assistant. . . . Mary Switzer, who was assistant to Josephine Roche, chairman of the Interdepartmental Committee to Coordinate Health and Welfare, which committee drafted the so-called National Health Program on which the Wagner Bill is based? . . . What do you think? . . . Incidentally the Wagner Bill is not dead . . . just slumbering. It, as well as all other proposals not acted upon at the recent session of Congress, will be on the agenda when Congress convenes next January.

But, let's turn from personalities and personnel for a moment to dig a bit deeper . . . let's try to understand some of the strategy (if that be not too mild a term) behind all these goings-on . . . there is the crux, anyway . . . the same group, Wagner, et al, will be on the job. . . . What will be the line of attack?

Again we quote from Pearson and Allen:

"There are two reasons behind this undercover strategy: First is the 1940 Presidential campaign. The administraton wants a broad-gauged public health program to its credit on the law books as 1940 approaches. In the spring of 1936, it enacted the Social Security Act and made big capital of it among voters.

"Second reason is that the New Dealers have learned that Dr. Glenn Frank, chairman of the Republican program committee, is secretly formulating a public health plan for use as a GOP ballot lure.

"Exact nature and extent of Frank's Republican program is not known but inside information in the hands of the White House group indicates that he aims to have the GOP offer the plan as a concrete illustration of the constructive things it will accomplish if elected, as compared with Democratic lack of accomplishment.

"Administrative masterminds are out to beat the Republicans to the punch and it will be McNutt's goal to steal the thunder by putting over a Democratic health program."

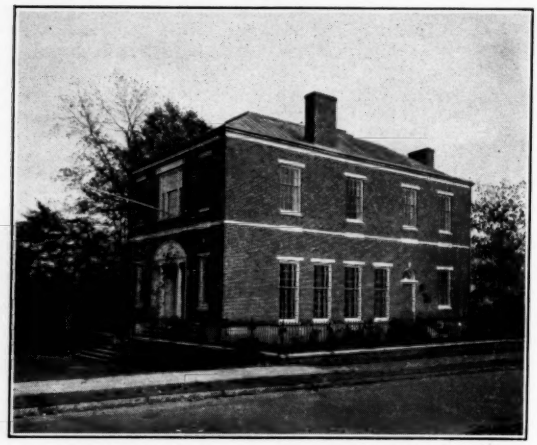
We can't vouch for the accuracy of the foregoing statements . . . to date we have not seen a denial from either Democratic or Republican leaders . . . we offer the observations for what they may be worth . . . only the future will reveal whether or not the health of the people is to become one of the political footballs of 1940.

There are other events which may not mean a thing . . . on the other hand they may be straws in the wind. For example . . . . Taft's address at laying of cornerstone of Doctors' Building, Washington, D. C. (published in full in this issue of *The Journal*) . . . Lodge's bill (S. 2963), introduced shortly before Congress adjourned, proposing to amend the Social Security Act to provide for a system of health insurance. . . . Lodge is a Republican member of the United States Senate. . . . Announcement by the Department of Justice in the public press that it will carry to the Supreme Court the verdict of Justice Proctor, Washington, D. C., holding the indictment of the A.M.A. under the anti-trust laws as invalid . . . indicating the campaign of prosecution (some term it persecution) against the medical profession will be continued by those who are so determined to socialize the practice of medicine that all rules of justice and fair play have been waived.

Yes siree . . . 1940 promises to be a big year . . . "battle of a century" . . . Political Medicine vs. Scientific Medicine . . . all rules off . . . no pulling of punches . . . public the referee. . . . Wonder if the public realizes the size of the stakes? . . . Physicians' job to give them the picture . . . straight from the shoulder.

AMERICA HAS NO ROOM FOR MEDICAL HITLERISM

THE SESQUI - CENTENNIAL OF THE MEDICAL SOCIETY OF DELAWARE 1789 — 1939



When the Medical Society of Delaware meets for its Annual Session on October 9, 10, and 11, it will have been a little over one hundred and fifty years since the group of twenty-seven physicians was authorized by an Act of Assembly, February 3, 1789, to incorporate the physicians of Delaware, a part of which Act follows: "Whereas, The practice of medicine is of acknowledged and extensive benefit to society, and therefore ought to be promoted and encouraged, and Whereas, It is of great consequence that the same should be conducted on some permanent establishment of regularity and permanent utility...."

Thus, this movement was made early in the history of our country, "in the thirteenth year of the Independence of the Delaware State." Only two such associations had been previously instituted in the United States: the first New Jersey in 1766, and the second Massachusetts in 1781.

The practice of medicine in those days was no simple task. Sometimes a physician used a gig, but he usually made his trips on horseback, carrying his stock of medicines—including the indispensable calomel and jalap, Peruvian bark, and Epsom salts—in his saddle bags. Most of the trips were made through the countryside; a contemporary map of Delaware shows only the following towns: Wilmington, New Port, New Castle, New Ark, Christiana Bridge, Saint George, and Port Penn in the northern part of the state; Middle Town, Nox Town, Salsbury, and Dover in the central part; and Saint Johns Town, Lewis Town, and Dagsbury in the southern part.

Too much credit cannot be given to that group of men, who, under circumstances often difficult and discouraging, when roads were wretched, traveling conveyances and inns anything but comfortable, sought to meet together for mutual improvement by discussing their observations and experiences, and endeavored to advance the knowledge of medicine beyond the prevailing ignorance of the public, who, too often, accepted the nostrums of ignorant and unscrupulous quacks. Too much credit cannot be given those men for the spirit evidenced in bringing the organization into being, nor to those who have followed them and sustained the prestige of the Medical Society of Delaware during its long history.

Some of the founders of the Society were prominent as physicians and surgeons; some also held conspicuous places of honor in the state and nation. We mention only a few of their names, and those but briefly:

John McKinley, born in Ireland, the first President of Delaware, was captured on the night after the battle of the Brandywine and held prisoner until the end of the war, when he returned to Wilmington and practiced his profession until his death, one of the most respected and honored of men; Joshua Clayton, an eminent practitioner of Bohemia Manor, was the last President and the first Governor of the state, was elected to the Senate of the United States, and died of yellow fever during his term of office; Nicholas Way was a noted physician of Wilmington where he practiced until 1796, when he was appointed by Washington as Director of the United States Mint in Philadelphia dying there of yellow fever the following year; George Monro of Wilmington, educated in Edinburgh and Philadelphia, was a surgeon in the Revolution and later a contributor to the first medical journal to be published in the United States, the *Medical Repository*. James McCalmont, of New Castle, was a sur-

geon in the Revolution, was captured by a Spanish privateer, and when about to "walk the plank" he and his brother were saved by the Masonic sign; Joseph Capelle, born in France, received his education and medical degree in that country, came to this country and served on the staff of LaFayette, later practicing in Wilmington; James Tilton of Dover, a surgeon in the Revolution, served one term in the Continental Congress, was the first President of the Medical Society of Delaware, came to Wilmington prior to 1792, was made Surgeon General of the Army in the War of 1812, returned to Wilmington where he practiced until his death in 1822; Edward Miller of Dover, also a surgeon in the Revolution, resumed his studies after the war, graduating from the University of Pennsylvania in 1785, was the first Secretary of the Society, removed to New York where he in conjunction with Dr. Samuel L. Mitchill and Dr. Elihu H. Smith originated the *Medical Repository*, which was published from 1797 to 1824; James Sykes of Dover, a distinguished physician, was the first Treasurer of the Society, its second President, and later, when President of the State Senate, was made Governor of the state from 1801 to 1802, when Governor Richard Bassett resigned; Henry Latimer of New Port, who began his education in Philadelphia, but finished his studies for the medical degree in Edinburgh, was a surgeon in the Revolution, served until the surrender at Yorktown, and received honorable mention by General Washington in one of his dispatches; and Julius Augustus Jackson of Sussex County, received a grant of land from William Penn, in the vicinity of the present town of Seaford, part of which land has recently been purchased for a large industrial plant by the duPont Company.

The meetings of the Annual Session of the Society will be held at the Delaware Academy of Medicine, in Wilmington. It is fitting that they should be held in a building which dates nearly as far back as the Society itself. The old Delaware Bank Building, now the Delaware Academy of Medicine, was chartered in 1795, and the present building was erected in 1816 at Sixth and Market Streets, where it stood until 1931, when it was removed to its present location along the Park Drive, on land adjacent to that once held by Tyman Stidham, the first doctor in Delaware. The building was re-erected exactly as it stood originally with the exception of a few interior alterations necessary for modern use. The original hand-hewn rafters joined with wooden pegs, the staircase, floors and trim have been preserved, as well as the original fence surrounding the building; all are as they appeared one hundred and twenty-three years ago.

An historical exhibit to help picture the medical background of the state has been arranged in the Library of the Academy, and includes photographs of physicians who have been President of the Society, old books, instruments, diplomas, fee bills, and many other items of special interest upon the occasion of the observance of the Sesqui-Centennial of the Society.

MONDAY, OCTOBER 9, 1939
MEETING OF THE
HOUSE OF DELEGATES
Delaware Academy of Medicine
8:30 P. M.

1. Call to order.
2. Roll call.
3. Reading of Minutes of Last Session.
4. Appointment of Committee on Nominations.
5. Reports of Officers.
6. Reports of Standing Committees.
7. Reports of Special Committees.
8. Report of Delegate to the A. M. A.
9. Report of Representative to the Delaware Academy of Medicine.
10. Unfinished Business.
11. New Business.
12. Adjournment.

TUESDAY, OCTOBER 10, 1939
GENERAL SESSION
Delaware Academy of Medicine
10:00 A. M.

Invocation

Reverend James H. Bishop, Dover.

10:10 A. M.—Address of Welcome:

Honorable Walter W. Bacon, Mayor of Wilmington.

10:30 A. M.—Report of the House of Delegates

11:00 A. M.—Address of the President

11:30 A. M.—"Sulfapyridine as a Bacterial Chemotherapeutic Agent."

E. K. Marshall, J., M. D.

The Johns Hopkins School of Medicine, Department of Pharmacology and Experimental Therapeutics, Baltimore, Maryland.

Discussion:

Lewis Booker, M. D., New Castle.

Joseph P. Waples, Jr., M. D., Georgetown.

12:30 P. M.—Luncheon by the New Castle County Medical Society; the Wilmington Country Club.

Guest Speaker:

John H. Foulger, M. D., Ph. D.

2:30 P. M.—Inspection, Haskell Laboratories, E. I. du Pont de Nemours & Co., Inc.—Courtesy G. H. Gehrmann, M. D.

7:00 P. M.—Smoker, Club Room, Hotel du Pont, Wilmington.

WEDNESDAY, OCTOBER 11, 1939
Delaware Academy of Medicine
10:00 A. M.

10:00 A. M.—"The Difficulty in Early Diagnosis of Primary Cancer of the Lung"

John T. Bauer, M. D.

Pathologist, The Pennsylvania Hospital, Philadelphia, Pennsylvania

Discussion:

Joseph M. Messick, M. D., Wilmington.

Lawrence D. Phillips, M. D., Faulkland.

10:30 A. M.—"Right Paraduodenal Hernia"

W. Edwin Bird, M. D., Wilmington

Discussion:

Lawrence J. Jones, M. D., Wilmington

Raymond A. Lynch, M. D., Wilmington

11:00 A. M.—"The Massive Resection of Bone Sarcoma with Immediate Bone Graft Replacement"—Illustrated

Fred Houdlett Albee, M. D., New York City.

Discussion:

Alfred R. Shands, M. D., Wilmington.

Irvine L. Flinn, M. D., Wilmington.

12:00 P. M.—Memorial to James Tilton, M.D., Wilmington and Brandywine Cemetery, Wilmington.

2:00 P. M.—"Hormone Therapy: Uses and Abuses."

Charles William Dunn, M. D., Philadelphia, Pa.

Discussion:

Mesrop A. Tarumianz, M. D., Farnhurst.

Clarence E. Prickett, M. D., Smyrna.

3:00 P. M.—"Ophthalmology and Its Relation to Industry"

Howard Cross, M. D., Chester, Pa.

Discussion:

William O. Lamotte, M. D., Wilmington.

Samuel Matthewson Donnel Marshall, M. D., Milford.

4:00 P. M.—Tea to all physicians and their wives—Courtesy Carl Henry Davis, M. D., 1100 Blackshire Road, Westover Hills, Wilmington

7:00 P. M.—Banquet to members of the Medical Society of Delaware, the Women's Auxiliary, and guests, by the Medical Society of Delaware, Hotel duPont.

WOMAN'S AUXILIARY
To The
Medical Society of Delaware
TUESDAY, OCTOBER 10, 1939
10th Annual Meeting

1:00 P. M.—Luncheon, by the Executive Committee in honor of Mrs. Rollo Packard, Hotel Darling.

2:30 P. M.—Longwood Gardens, courtesy of Mr. and Mrs. P. S. du Pont.

7:00 P. M.—Dinner in honor of Mrs. Rollo Packard, President, Woman's Auxiliary to American Medical Association, and Mrs. Rock Sleyster.

Wilmington Country Club.

Guests: Officers of the Medical Society of Delaware.

12:00—Memorial to James Tilton, M. D., Wilmington and Brandywine Cemetery.

2:00 P. M.—Tenth Annual Business Meeting, Hotel du Pont.

2 P. M.

PRAYER

REPORTS OF OFFICERS

President ..... MRS. IRA BURNS
Treasurer ..... MRS. WILLARD PRESTON
Secretary ..... MRS. HAROLD TARRANT
National Delegate ..... MRS. IRA BURNS
Report of Nominating Committee,
MRS. P. R. SMITH

REPORTS OF STANDING COMMITTEES

Archives ..... MRS. S. D. RENNIE
Exhibits ..... MRS. J. H. MULLIN
Flowers ..... MRS. C. E. WAGNER
Finance ..... MRS. W. O. LA MOTTE
Hospitality ..... MRS. A. L. HECK
Hygeia ..... MRS. W. E. BIRD
Legislation ..... MRS. R. W. TOMLINSON
Membership ..... MRS. G. C. MCELFATRICK
Press and Publicity..MRS. M. A. TARUMIANZ
Printing ..... MRS. J. W. BUTLER
Program ..... MRS. L. J. JONES
Public Relations ..... MRS. N. W. VOSS
Revisions ..... MRS. E. R. MAYERBERG
Sewing ..... MRS. D. D. BURCH

UNFINISHED BUSINESS

NEW BUSINESS

4:00 P. M.—Tea, Dr. and Mrs. Carl Henry Davis, 1100 Blackshire Road, Wilmington, in honor of Dr. Rock Sleyster, President of the American Medical Association, and Mrs. Sleyster.

7:00 P. M.—Banquet, with Medical Society, Hotel du Pont.

FIFTIETH ANNIVERSARY
Delaware State Hospital

On Thursday, September 28th, at one thirty P. M. the Delaware State Hospital will celebrate its 50th Anniversary, and at the same time will dedicate the newly erected chapel, with its color organ.

Delaware was the first state to assume the full responsibility of the care and treatment of its mentally ill, and for these fifty years the Delaware State Hospital has consistently been in the vanguard.

The neighboring state and national organizations have been invited to attend this event, as well as the members of the Medical Society.

The program is as follows:

Dedication of the Chapel ..... Rt. Rev. Arthur R. McKinstry, Bishop of Delaware, Most Rev. Edmond J. FitzMaurice, Bishop of Wilmington, assisted by the Chaplains of the Hospital, Dr. Joseph Earp, Rev. Roderick Dwyer and Rabbi Henry Tavel.

Opening Remarks .....
M. A. Tarumianz, M. D., Superintendent

Greetings by:
His Excellency, Richard C. McMullen, Governor of the State of Delaware.
Hon. John G. Townsend, Jr., U. S. Senator.
Hon. James M. Hughes, U. S. Senator.
Hon. George S. Williams, U. S. Congressman.
Horatio M. Pollock, M. D., Director, Mental Hygiene Statistics, officially representing Gov. Herbert H. Lehman and the State of New York.
Mr. John Colt, Director, Division of Parole, Dept. of Institutions and Agencies, officially representing Gov. A. Harry Moore and the State of New Jersey.
George H. Preston, M. D., Commissioner of Mental Hygiene, officially representing Gov. Herbert R. O'Conor and the State of Maryland.
An official representative of the Commonwealth of Pennsylvania.
Hon. Edward Cooch, Lieut. Governor of the State of Delaware.
Hon. David W. Steele, President Pro Tem of the Senate.
Hon. Frank R. Zebley, Speaker of the House of Representatives.
William C. Sandy, M. D., President of the American Psychiatric Association.
Arthur H. Ruggles, M. D., President of National Committee of Mental Hygiene.
Adolf Meyer, M. D., Psychiatrist-in-chief, Johns Hopkins Hospital.
Lawrence Kolb, M. D., Assistant Surgeon General, U. S. Public Health Service.
C. M. Hincks, M. D., General Director of the National Committee for Mental Hygiene in Canada.
Winfred Overholser, M. D., Supt., St. Elizabeth's Hospital, Washington.
Hon. Daniel J. Layton, Chief Justice of the State of Delaware.
Hon. Walter W. Bacon, Mayor of City of Wilmington.
Meredith I. Samuel, M. D., President of the Medical Society of Delaware.
Mr. F. V. duPont, President of Mental Hygiene Society of Delaware.
Mr. J. Warren Marshall, President of the Chamber of Commerce of Wilmington.
Mr. Fred H. Gawthrop, President of the State Board of Trustees.

Address:
"Social Implications of Psychiatry" ..... Edward A. Strecker, M. D., Professor of Psychiatry, University of Pennsylvania.

Remarks in Regard to the Color Organ .....
Mrs. Mary Hallock Greenewalt

Music will be rendered by The Thoms Ensemble, consisting of John Thoms, organist and director, Harry E. Stausebach, violinist, John Gray, violincellist, Frank Nicoletta, harpist. Refreshments will be served at the conclusion of the program.

Psychoneuroses in Relation to General Medicine

(*Concluded from page 200*)

up of his special mental characteristics. The latter render him highly suggestible, highly sensitive, and highly emotional. While they do not present new phenomena which are not observed in normal individuals, their re-

action, however, to all kinds of stimuli is expressed in a greater intensity and is reproduced with a greater facility and branches out in a most unexpected manner. The complexes which were described above and which we consider as the result of conflicts between the instinctive emotional elements and the environmental occurrences are not easily recognized, and they are not properly interpreted when recognized by psychoneurotic personalities because of peculiar characteristics. The complexes which arise in them are more numerous, more antagonistic to each other because of the greater intensity of each emotional element which enters into the formation of the complexes. The environmental factors which also form a part of the complexes equally give a different sensorial impression in the psychoneurotics, and consequently the mental representation in the latter will correspondingly be different from that of normal individuals.

The methods employed in the management of psychoneuroses are several. The object of the present thesis is not the discussion of methods or procedures in bringing to the surface the modus operandi of the complexes which are the basis of psychoneurotic phenomena. My sole purpose is to call attention to the fact that all those abnormal manifestations are too phychic in character, that the functional disorders of which the victims complain are too much dependent upon special mental attitudes to be attributed exclusively to organic disorders of tissues and organs. Psychoneurotics are psychopathic individuals. They occupy a place between insane and normal. Their number is legion and their multiple manifestations present infinite varieties and subvarieties. The latter are intermingled and mixed with human suffering in all its forms and degrees, medical as well as surgical.

In dealing with human life it behooves us medical men to approach its phenomena not only from a purely biological but also from a psychological standpoint. The former has for its object the adaptation of the individual to his environment. The latter is to have him adapted to himself. It is only after the latter task has been successfully accomplished that the individual will be fit to face his environment. No removal of tissues or organs, no artificial correction of disturbances, however accurately or skillfully they may be done, will succeed in making a psychoneurotic discard his fixed ideas, his hypochondriasis, his abulias, his fears or his obsessions, if he or she is not taught properly how to restore peace amidst the bewildering complexes.

1900 Locust St.

Academy of Opthalmology and Otolaryngology

The forty-fourth annual meeting of the American Academy of Ophthalmology and Otolaryngology will be held in Chicago, October 8-13, at the Palmer House. The Academy will again present its elaborate courses of instruction with more than 100 specialists as teachers; four afternoon programs of motion pictures and a scientific exhibit in addition to its formal scientific program.

There will be one joint session at which Dr. George M. Coates, Philadelphia, will deliver his presidential address, and Dr. Burt R. Shurly, Detroit, will be introduced as the Academy's guest of honor for the year and will deliver an address.

At this session a symposium on essential hypertension will be presented by Drs. Albert C. Furstenberg, Ann Arbor, Mich., speaking from the standpoint of the otolaryngologist; Henry P. Wagener, Rochester, Minn., the ophthalmologist, and Roy W. Scott, Cleveland, the internist.

Two foreign guests will address the section meetings, which will be held on alternate afternoons. These guests are Prof. Joseph Igersheimer, Istanbul, Turkey, who will discuss "The Optic Nerve and Diseases of Hypertension," and Arthur DeSa, Pernambuco, Brazil, who is to speak on "Ethmoiditis."

American Board of Obstetrics and Gynecology

The next written examination and review of case histories (Part I) for Group B candidates will be held in various cities of the United States and Canada on Saturday, January 6, 1940, at 2:00 p. m. The Board an-

nounces that it will hold only one Group B, Part I, examination this year prior to the final general examination (Part II) instead of two as in former years. Candidates who successfully complete the PART I examination proceed automatically to the Part II examination held in June 1940.

Applications for admission to Group B, Part I, examinations must be on file in the Secretary's office not later than October 4, 1939.

For further information and application blanks, address Dr. Paul Titus, Secretary, 1015 Highland Building, Pittsburgh (6), Pennsylvania.

BOOK REVIEWS

New and Non-Official Remedies, 1939. By the Council of Pharmacy and Chemistry of the A. M. A. Pp. 684. Cloth. Price, $1.50. Chicago: American Medical Association, 1939.

This volume lists and describes the medicinals that stand accepted by the Council, as of January 1, 1939. As the title indicates, these preparations are relatively new, and hence are not to be found in the U. S. P. or the N. F. Articles having a similar composition or action are grouped together, preceded by a general discussion, which has been brought up to date. Included also is a list of articles deleted because they conflict with the rules of the Council or have been withdrawn from the market. The work concludes with a bibliographical index of articles not included in N. N. R.

For the general practitioner who wishes to keep informed on the newer remedies this is the only critical and authoritative work published in this country.

Medicolegal Phases of Occupational Diseases. By C. O. Sappington, M. D., Ph. D. Price, $2.75. Chicago: Industrial Health Book Company, 1939.

This book, written by an authority, is particularly opportune, as industrial medicine and occupational diseases are being stressed at the present time, and involve numerous difficult problems. The material of the book has been divided into four parts: Industrial, Insurance, Medical, and Legal, and the relationships of the personnel of each of these divisions are shown throughout the text, indicating the necessity of the business executive, the insurance carrier, the industrial physician, and the lawyer cooperating in the solution of common problems. The style is clear and concise.

There is an excellent Appendix, including Occupational Record, Abstracts of State Laws, Scheduled Diseases, Abstracts of Legal Decisions, Legislative Suggestions of the American Bar Association, Suggested Schedule Law recommended by the American Public Health Association, and a Digest of Workmen's Compensation Laws, by States. Twenty-nine tables illuminate the text to good advantage, as well as illustrations of some of the apparatus used in industrial hygiene activities. The book is well indexed.

The general practitioner must have knowledge of at least the fundamental principles of industrial medicine, and hygiene, and occupational diseases, so that he may properly evaluate the etiologic factors of actual or alleged occupational diseases which may come to his attention. He will find this volume of great value in this respect.

Diseases of the Nose and Throat. By Charles J. Imperatori, M. D., Professor of Otolaryngology, New York Polyclinic Medical School, and Herman J. Burman, M. D., Adjunct Professor of Otolaryngology, New York Polyclinic Medical School. Second edition. Pp. 700, with 480 illustrations. Cloth. Price $7.00. Philadelphia: J. B. Lippincott Company, 1939.

The first edition of this book appeared in 1935. To the second edition have been added discussions of dermoid cysts of the nose, the cytology of nasal secretions, fractures of the nasal sinuses, etc. External ethmoidectomy is described in less than one and one-half pages, without any illustrations. In fact, about everything involving the nose and throat has been included in some fashion. The book is, in a measure, a large compend. Some presentations are so superficial that harm could result from them. For example, instructions on page 471 for treating tuberculosis of the

larynx with the galvanocautery are as follows: "The cautery point is usually inserted cold into the tissues, and then the current is turned on, but occasionally when the tissues are resistant, especially in edema, the current must be on as the puncture is being made. Remove the cautery with the current on." With no more knowledge than that the operator might produce very serious results.

There are very good pictures of microscopic sections included, and there are many other good features in the book. It should be found useful especially if its use is accompanied with other reading and with clinical and surgical experience.

The Infant and Child in Health and Disease. By John Zahorsky, Professor of Pediatrics, St. Louis University, Missouri; and Elizabeth Noyes, R. N., Supervisor of Pediatrics, Children's Hospital, San Francisco. Second edition. Pp. 496, with 147 illustrations. Cloth. Price, $3.00. St. Louis: C. V. Mosby Company, 1939.

This work is well planned, as a text for nurses. Part I is devoted to the normal infant and child, Part II describes the diseases of infants and children; and Part III explains the methods by which treatments are carried out.

The book is very well written and the material is presented in an orderly manner. The illustrations are excellent. It is a book which the student nurse ought to find of value to her.

Baptism of the Infant and the Fetus. By the Rev. J. R. Bowen, chaplain, St. Joseph Mercy Hospital, Dubuque, Iowa. Fourth edition. Pp. 12. Paper. Price, 25 cents. Dubuque: M. J. Knippel Company, 1939.

This little brochure, published under the authority of the Catholic church, is directed to Catholic and non-Catholic physicians and nurses officiating at deliveries of Catholic babies. Every possible contingency is herein anticipated, and appropriate instructions for the same are included. The text is clear and brief. For the consolation of Catholic parents this pamphlet should be on hand in every maternity department.